INDIVIDUAL'S AUTHORIZATION
SUBSTANCE USE DISORDER INFORMATION

Purpose: This form is used to confirm the direction of an individual to authorize MDH to request, to use, or to disclose the individual's substance use disorder information.

Please type or print neatly; we are not able to process incomplete or illegible forms.

☐ **Check if this authorization is for psychotherapy notes only.**

If this authorization is for psychotherapy notes, MDH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

SECTION A: Individual's Information

Last Name:_____ First Name:_____ MI: _____

Street Address:_____ Apt #: _____

City:_____ State:_____ Zip:_____

Phone: (home)_____ (work)_____ Date of Birth: ___/___/___

SECTION B: The Use and/or Disclosure being authorized

I understand that in addition to Maryland confidentiality laws, my substance use disorder records are also protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Disclose: (provide a detailed description of how much and what kind of information may be disclosed, including an explicit description of what substance use disorder information that MDH may disclose; as limited as possible)

For the purpose of: (describe the purpose of the disclosure; as specific as possible)

Who is authorized to disclose your substance use disorder information: (name or general designation of individual or entity making the disclosure)

MDH PROGRAM NAME(S): _____ **ADDRESS:** _____

TELEPHONE NUMBER: _____

To whom: (who is authorized to Receive and Use your substance use disorder information)

NAME(S): _____ **ADDRESS:** _____

TELEPHONE NUMBER: _____

If the information which the program has includes records or information from another entity, I ___ do or ____ do not wish to have that information released under this authorization.

SECTION C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, MDH CANNOT ACCEPT THIS FORM.)

This authorization will expire on the earlier of the date or event listed below or one year from the date that it is signed.

Section 4-303(b) of the Health-General Article limits the period of time that an authorization is valid to no more than one year with limited exceptions.

Expiration: This authorization will expire (complete one):

- ☐ On ___/___/_____
- ☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):
  _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to MDH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact _____. I understand that revocation of this authorization will not affect any action that MDH or others named or unnamed took in reliance on this authorization before MDH received my written notice of revocation.

SECTION D: Signature.

To the Individual – Please read the following.

I authorize the use and/or disclosure of my substance use disorder information as described in Section B above. I understand this authorization is voluntary.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment or health care operations if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

I have been provided a copy of this form.

Signature: _____Date: _____

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____